

Enrollment Form CDDP Colorectal (CRC)

Instructions: The Enrollment Form should be completed for each CDDP qualified case, upon qualification notice from the BCR. All information provided on this form should include activity from the date of initial diagnosis to the most recent date of contact with the patient ("Date of Initial Pathologic Diagnosis" and "Date of Last Contact" on this form).

Questions regarding this form should be directed to the Tissue Source Site's primary Clinical Outreach Contact at the BCR.

Please note the following definitions for the "Unknown" and "Not Evaluated" answer options on this form.

Unknown: This answer option should only be selected if the TSS does not know this information after all efforts to obtain the data have been exhausted. If this answer option is selected for a question that is part of the CDDP required data set, the TSS must complete a discrepancy note providing a reason why the answer is unknown.

Not Evaluated: This answer option should only be selected by the TSS if it is known that the information being requested cannot be obtained. This could be because the test in question was never performed on the patient or the TSS knows that the information requested was never disclosed.

Tissue Source Site (TSS): _____ TSS Identifier: _____ TSS Unique Patient Identifier: _____

Completed By (Interviewer Name in OpenClinica): _____ Completed Date: _____

General Information

#	Data Element	Entry Alternatives	Working Instructions
Collection Information			
1*	Is this a prospective tissue collection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate whether the TSS providing tissue is contracted for prospective tissue collection. If the submitted tissue was collected for the specific purpose of CDDP, the tissue has been collected prospectively. 3088492
2*	Is this a retrospective tissue collection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate whether the TSS providing tissue is contracted for retrospective tissue collection. If the submitted tissue was collected prior to the date the CDDP contract was executed, the tissue has been collected retrospectively. 3088528

Patient Information

Demographics			
3*	Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male	Provide the patient's gender using the defined categories. 2200604
4*	Date of Birth	_____ <i>Month Day Year</i>	Provide the date the patient was born. 2896950 (Month), 2896952 (Day), 2896954 (Year)
5	Patient Height <i>(at time of diagnosis)</i>	_____ (cm)	Provide the patient's height (in centimeters) at the time the patient was diagnosed with the malignancy being submitted for CDDP. 649
6	Patient Weight <i>(at time of diagnosis)</i>	_____ (kg)	Provide the patient's weight (in kilograms) at the time the patient was diagnosed with the malignancy being submitted for CDDP. 651
7*	Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander: <input type="checkbox"/> Not Reported <input type="checkbox"/> Unknown	Provide the patient's race using the defined categories. 2192199 American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. Asian: A person having origins in any of the original peoples of the far East, Southeast Asia, or in the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. Black or African American: A person having origins in any of any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American." Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Enrollment Form
CDDP Colorectal (CRC)

#	Data Element	Entry Alternatives	Working Instructions
18	Performance Status Scale: Eastern Cooperative Oncology Group (ECOG) at Time of Diagnosis	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	Provide the patient's Eastern Cooperative Oncology Group (ECOG) score using the defined categories. This score represents the functional performance status of the patient. 38 0: Asymptomatic 1: Symptomatic, but fully ambulatory 2: Symptomatic, in bed less than 50% of day 3: Symptomatic, in bed more than 50% of day, but not bed-ridden 4: Bed-ridden
19	Performance Status Score: Karnofsky Score At Time of Diagnosis	<input type="checkbox"/> 100 <input type="checkbox"/> 90 <input type="checkbox"/> 80 <input type="checkbox"/> 70 <input type="checkbox"/> 60 <input type="checkbox"/> 50 <input type="checkbox"/> 40 <input type="checkbox"/> 30 <input type="checkbox"/> 20 <input type="checkbox"/> 10 <input type="checkbox"/> 0 <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	Provide the patient's Karnofsky Score using the defined categories. This score represents the functional capabilities of the patient. 2003853 100: Normal, no complaints; no evidence of disease 90: Able to carry on normal activity; minor signs or symptoms of disease 80: Normal activity with effort; some signs or symptoms of disease 70: Cares for self; unable to carry on normal activity or to do active work 60: Requires occasional assistance; but is able to care for most of his/her needs 50: Requires considerable assistance and frequent medical care 40: Disabled; requires special care 30: Severely disabled 20: Very sick; requiring hospitalization 10: Moribund; fatal processes progressing rapidly 0: Dead <u>Not Evaluated</u> <u>Unknown</u>

CDDP Tumor Information

Anatomic Information

20*	Primary Site of Disease	<input type="checkbox"/> Colon	Using the patient's pathology/laboratory report, select the anatomic site of disease of the tumor submitted for CDDP. 3427536
21	Region of Tumor	<input type="checkbox"/> Colon, NOS <input type="checkbox"/> Cecum <input type="checkbox"/> Sigmoid Colon <input type="checkbox"/> Splenic Flexure <input type="checkbox"/> Ascending Colon <input type="checkbox"/> Hepatic Flexure <input type="checkbox"/> Descending Colon <input type="checkbox"/> Transverse Colon	Using the patient's pathology/laboratory report, select the anatomic organ sub-division of the tumor used for CDDP. 3108203

Pathologic Information

22*	Histological Subtype	<input type="checkbox"/> Colon Adenocarcinoma <input type="checkbox"/> Colon Mucinous Adenocarcinoma	Indicate the histologic subtype of the malignant sample submitted. 3081934
23*	Date of Initial Pathological Diagnosis	_____ <i>Month Day Year</i>	Provide the date the patient was initially pathologically diagnosed with the malignancy submitted. 2896956 (month), 2896958 (day), 2896960 (year)
24	Method of Initial Pathologic Diagnosis	<input type="checkbox"/> Right Hemicolectomy <input type="checkbox"/> Left Hemicolectomy <input type="checkbox"/> Transverse Colectomy <input type="checkbox"/> Sigmoid Colectomy <input type="checkbox"/> Total Colectomy <input type="checkbox"/> Pan-Procto Colectomy <input type="checkbox"/> Low Anterior Colon Resection <input type="checkbox"/> Other Surgical Resection	Provide the procedure used to initially diagnose the patient. This is the method used on the date provided above. 2757941
25	Non-nodal Tumor Deposits (TD) in Resected Specimen	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate the pathologic presence of tumor deposits in the pericolic fat or in adjacent mesentery away from the leading edge of the tumor submitted to CDDP. 3107051
26	Circumferential Resection Margin (CRM) (also known as radial surgical clearance)	_____ (mm)	Indicate the measured length (mm) between a malignant lesion of the colon and the nearest radial (or circumferential) border of tissue removed during surgery for the tumor submitted to CDDP. 64202
27	Vascular Invasion Present	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate if large vessel or venous invasion was pathologically present in the tumor specimen submitted to CDDP. 64358

Enrollment Form CDDP Colorectal (CRC)

#	Data Element	Entry Alternatives	Working Instructions
28	Lymphatic Invasion Present	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate if malignant cells are pathologically present in small or thin walled vessels suggesting lymphatic involvement in the tumor submitted to CDDP. 64171
29	Perineural Invasion Present	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate if perineural invasion or infiltration of tumor or cancer is pathologically present in tumor submitted to CDDP. 64181
30	Residual Tumor	<input type="checkbox"/> RX <input type="checkbox"/> R0 <input type="checkbox"/> R1 <input type="checkbox"/> R2 <input type="checkbox"/> Not Evaluated	Using the patient's pathology/laboratory report, select the tissue margin status at time of surgical resection for the tumor submitted for CDDP. 2608702
31	Were Lymph Nodes Examined at the time of Primary Presentation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate whether any lymph nodes were examined at the time of the primary resection for the tumor submitted to CDDP. 2200396
32	Number of Lymph Nodes Examined	_____	If the patient's lymph nodes were examined, using the patient's pathology/laboratory report, indicate the number of lymph nodes examined. 3
33	Number of Lymph Nodes Positive by H&E Light Microscopy	_____	If the patient had at least one positive lymph node, using the patient's pathology/laboratory report, indicate the number of lymph nodes determined to be positive by H&E microscopy. 3086388
34	Number of Lymph Nodes Positive by IHC Keratin Staining ONLY	_____	If the patient had at least one positive lymph node, using the patient's pathology/laboratory report, indicate the number of lymph nodes determined to be positive by IHC keratin staining. 3086383
35*	What type of staging information is available for this diagnosis? (check all that apply)	<input type="checkbox"/> Pathologic <input type="checkbox"/> Clinical	Indicate whether pathologic, clinical or both pathologic and clinical staging information is available for the patient's diagnosis of cancer that yielded the tumor submitted for CDDP. 3370189
36*	AJCC Cancer Staging Handbook Edition	<input type="checkbox"/> First Edition (1978-1983) <input type="checkbox"/> Second Edition (1984-1988) <input type="checkbox"/> Third Edition (1989-1992) <input type="checkbox"/> Fourth Edition (1993-1997) <input type="checkbox"/> Fifth Edition (1998-2002) <input type="checkbox"/> Sixth Edition (2003-2009) <input type="checkbox"/> Seventh Edition (2010-Current)	Indicate the AJCC Cancer Staging Edition that was used to answer the following staging questions. 2722309
Pathologic Information			
37	Primary Tumor: Pathologic (pT)	<input type="checkbox"/> TX <input type="checkbox"/> T0 <input type="checkbox"/> Tis <input type="checkbox"/> T1 <input type="checkbox"/> T1a <input type="checkbox"/> T1b <input type="checkbox"/> T2 <input type="checkbox"/> T2a <input type="checkbox"/> T2b <input type="checkbox"/> T3 <input type="checkbox"/> T4 <input type="checkbox"/> T4a <input type="checkbox"/> T4b	Using the patient's pathology/laboratory report, select the code for the pathologic T (primary tumor) as defined by the American Joint Committee on Cancer (AJCC). 3045435
38	Regional Lymph Nodes: Pathologic (pN)	<input type="checkbox"/> NX <input type="checkbox"/> N0 <input type="checkbox"/> N1 <input type="checkbox"/> N1a <input type="checkbox"/> N1b <input type="checkbox"/> N1c <input type="checkbox"/> N2 <input type="checkbox"/> N2a <input type="checkbox"/> N2b <input type="checkbox"/> N3	Using the patient's pathology/laboratory report, select the code for the pathologic N (nodal) as defined by the American Joint Committee on Cancer (AJCC). 3203106
39	Distant Metastasis: Pathologic (M)	<input type="checkbox"/> MX <input type="checkbox"/> M0 <input type="checkbox"/> M1 <input type="checkbox"/> M1a <input type="checkbox"/> M1b	Using the patient's pathology/laboratory report in conjunction with the patient's medical record, select the code for pathological M (metastasis) as defined by the American Joint Committee on Cancer (AJCC). 3045439
40	Overall Stage: Pathologic	<input type="checkbox"/> Stage I <input type="checkbox"/> Stage IA <input type="checkbox"/> Stage IB <input type="checkbox"/> Stage II <input type="checkbox"/> Stage IIA <input type="checkbox"/> Stage IIB <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IIIA <input type="checkbox"/> Stage IIIB <input type="checkbox"/> Stage IV	Using the patient's pathology/laboratory report, in conjunction with the patient's medical record select the stage as defined by the American Joint Committee on Cancer (AJCC). 3203222
Clinical Information			
41	Primary Tumor: Clinical (cT)	<input type="checkbox"/> TX <input type="checkbox"/> T0 <input type="checkbox"/> Tis <input type="checkbox"/> T1 <input type="checkbox"/> T1a <input type="checkbox"/> T1b <input type="checkbox"/> T2 <input type="checkbox"/> T2a <input type="checkbox"/> T2b <input type="checkbox"/> T3 <input type="checkbox"/> T4 <input type="checkbox"/> T4a <input type="checkbox"/> T4b	Using the patient's medical record, select the code for the clinical T (primary tumor) as defined by the American Joint Committee on Cancer (AJCC). 3440328

Enrollment Form CDDP Colorectal (CRC)

#	Data Element	Entry Alternatives	Working Instructions															
42	Regional Lymph Nodes: Clinical (cN)	<input type="checkbox"/> NX <input type="checkbox"/> N1b <input type="checkbox"/> N2a <input type="checkbox"/> N0 <input type="checkbox"/> N1c <input type="checkbox"/> N2b <input type="checkbox"/> N1 <input type="checkbox"/> N2 <input type="checkbox"/> N3 <input type="checkbox"/> N1a	Using the patient's medical record, select the code for the clinical N (nodal) as defined by the American Joint Committee on Cancer (AJCC). 3440330															
43	Distant Metastasis: Clinical (M)	<input type="checkbox"/> MX <input type="checkbox"/> M1a <input type="checkbox"/> M0 <input type="checkbox"/> M1b <input type="checkbox"/> M1	Using the patient's pathology/laboratory report in conjunction with the patient's medical record, select the code for the clinical M (metastasis) as defined by the American Joint Committee on Cancer (AJCC). 3440331															
44	Overall Stage: Clinical	<input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IA <input type="checkbox"/> Stage IIA <input type="checkbox"/> Stage IIIA <input type="checkbox"/> Stage IB <input type="checkbox"/> Stage IIB <input type="checkbox"/> Stage IIIB <input type="checkbox"/> Stage IV	Using the patient's pathology/laboratory report, in conjunction with the patient's medical record select the stage as defined by the American Joint Committee on Cancer (AJCC). 3440332															
45	Preoperative / Pretreatment CEA Level	_____ (ng/ml)	Provide the carcinoembryonic antigen or CEA level (ng/ml) prior to the resection of tumor submitted to CDDP. 2716510															
Molecular/Genomic Information																		
46	Microsatellite Instability (Abnormal at >33% loci tested)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether microsatellite instability was present in more than 33% of loci tested in the tumor submitted to CDDP. 3123142															
47	Number of Loci Tested	_____	If microsatellite instability was identified, indicate the number of loci tested to detect recessive mutations in the tumor submitted to CDDP. 3107127															
50	Number of Abnormal Loci	_____	Indicate the number of loci found to be abnormal during testing to detect microsatellite instability in the tumor submitted to CDDP. 3107129															
51	Was Loss of Expression of Mismatch Repair Proteins Tested (by IHC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate if testing was performed to identify any loss of expression in mismatch repair proteins tested by immunohistochemistry (IHC). 3123153 Note: If not performed, skip to the KRAS gene questions.															
52	Loss of Expression of mismatch Repair Proteins by IHC	<table border="1"> <thead> <tr> <th>Gene</th> <th>Expressed</th> <th>Not Expressed</th> </tr> </thead> <tbody> <tr> <td>MLH1</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>MSH2</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>PMS2</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>MSH6</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>	Gene	Expressed	Not Expressed	MLH1	<input type="checkbox"/>	<input type="checkbox"/>	MSH2	<input type="checkbox"/>	<input type="checkbox"/>	PMS2	<input type="checkbox"/>	<input type="checkbox"/>	MSH6	<input type="checkbox"/>	<input type="checkbox"/>	Indicate if any loss of expression of mismatch repair proteins by immunohistochemistry (IHC) is expressed for each of the listed genes. 3105496
Gene	Expressed	Not Expressed																
MLH1	<input type="checkbox"/>	<input type="checkbox"/>																
MSH2	<input type="checkbox"/>	<input type="checkbox"/>																
PMS2	<input type="checkbox"/>	<input type="checkbox"/>																
MSH6	<input type="checkbox"/>	<input type="checkbox"/>																
53	KRAS Gene Analysis Performed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate if KRAS gene analysis was performed on the tumor submitted for CDDP. Note: If not performed, skip to BRAF gene questions. 3123147															
54	Mutation Found (KRAS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If KRAS Gene Analysis was performed, indicate if KRAS Mutation was found. 2932340															
55	If KRAS Mutation Identified, What Codon?	<input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 61 <input type="checkbox"/> Other	If KRAS mutation was identified, indicate the specific codon. 3124509															
56	BRAF Gene Analysis Performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate if BRAF gene analysis was performed on tumor submitted for CDDP. 3123151															
57	BRAF Gene Analysis Results	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	If BRAF gene analysis was performed, indicate the result. 3107189															
Treatment Information																		

Enrollment Form CDDP Colorectal (CRC)

#	Data Element	Entry Alternatives	Working Instructions
58*	History of Neo-adjuvant Treatment for Sample Submitted for CDDP	<input type="checkbox"/> None <input type="checkbox"/> Radiation prior to sample procurement* <input type="checkbox"/> Pharmaceutical treatment prior to sample procurement* <input type="checkbox"/> Both pharmaceutical treatment and radiation prior to sample procurement*	Indicate whether the patient received therapy for this cancer prior to the sample procurement of the tumor submitted for CDDP. If the patient did receive treatment for this cancer prior to procurement, the TSS should contact the BCR for further instruction. 3382737 *Systemic therapy and certain localized therapies (those administered to the same site as the CDDP submitted tissue) given prior to the procurement of the sample submitted for CDDP are exclusionary.
59*	Adjuvant (Post-Operative) Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient had adjuvant/ post-operative radiation therapy <i>for the tumor submitted</i> . 2005312 If the patient did have adjuvant radiation, the Radiation Supplemental Form should be completed.
60*	Adjuvant (Post-Operative) Pharmaceutical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient had adjuvant/ post-operative pharmaceutical therapy <i>for the tumor submitted</i> . 3397567 If the patient did have adjuvant pharmaceutical therapy, the Pharmaceutical Supplemental Form should be completed.
61	Measure of Success of Outcome at the Completion of Initial First Course Treatment (surgery and/or adjuvant therapies)	<input type="checkbox"/> Progressive Disease <input type="checkbox"/> Complete Response <input type="checkbox"/> Stable Disease <input type="checkbox"/> Not Applicable <input type="checkbox"/> Partial Response <input type="checkbox"/> Unknown	Provide the patient's response to their initial first course treatment (surgery and/or adjuvant therapies). 2786727
Survival Information			
62*	Vital Status (at date of last contact)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Indicate whether the patient was living or deceased at the date of last contact. 5
63	Date of Last Contact	_____ <i>Month Day Year</i>	Provide the date of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). 2897020 (Month), 2897022 (Day), 2897024 (Year) Do not answer if patient is deceased.
64	Date of Death	_____ <i>Month Day Year</i>	If the patient is deceased, provide the date of death. 2897026 (Month), 2897028 (Day), 2897030 (Year)
65*	Tumor Status (at time of last contact or death)	<input type="checkbox"/> Tumor free <input type="checkbox"/> With tumor <input type="checkbox"/> Unknown Tumor Status	Indicate whether the patient was tumor/disease free (i.e. free of the malignancy that yielded the sample submitted for the CDDP study) at the date of last contact or death. 2759550
New Tumor Event Information Complete the section below if the patient had a new tumor event after tissue procurement and prior to submission of the Enrollment Form. If the patient did not have a new tumor event (or if the TSS does not know) indicate this in the question below, and the remainder of this section can be skipped.			
66*	New Tumor Event After Initial Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient had a new tumor event (e.g. metastatic, recurrent, or new primary tumor) after initial treatment for the tumor submitted to CDDP. 3121376 If the patient did not have a new tumor event or if this is unknown, the remaining questions can be skipped.
67	Date of New Tumor Event	_____ <i>Month Day Year</i>	If the patient had a new tumor event, provide the date of diagnosis for this new tumor event. 3104044 (Month), 3104042 (Day), 3104046 (Year)
68	Type of New Tumor Event	<input type="checkbox"/> Locoregional Recurrence <input type="checkbox"/> Distant Metastasis <input type="checkbox"/> New Primary Tumor	Indicate whether the patient's new tumor event was a locoregional recurrence or a distant metastasis of the tissue submitted for CDDP; or a new primary tumor. 3119721
69	Anatomic Site of New Tumor Event	<input type="checkbox"/> Bone <input type="checkbox"/> Retroperitoneum <input type="checkbox"/> Lung <input type="checkbox"/> Lymph Node(s) <input type="checkbox"/> Liver <input type="checkbox"/> Other, specify	Indicate the site of this new tumor event. 3108271

Enrollment Form CDDP Colorectal (CRC)

#	Data Element	Entry Alternatives	Working Instructions
70	Other Anatomic Site of New Tumor Event	_____	If the site of the new tumor event is not included in the provided list, describe the site of this new tumor event. 3128033
71	Diagnostic Evidence of Recurrence / Relapse (check all that apply)	<input type="checkbox"/> Biopsy with Histologic Confirmation <input type="checkbox"/> Convincing Imaging (i.e. CT, PET, MRI) <input type="checkbox"/> Positive Biomarker(s)	Indicate the procedure or testing method used to diagnose tumor recurrence or relapse. 2786205
72	Additional Surgery for New Tumor Event	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Using the patient's medical records, indicate whether the patient had surgery for the new metastatic tumor event in question. 3427611
73	Additional Treatment of New Tumor Event: Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient received radiation treatment for this new tumor event. 3427615
74	Additional Treatment of New Tumor Event: Pharmaceutical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient received pharmaceutical treatment for this new tumor event. 3427616

Time Intervals: The following questions are only to be answered if the Tissue Source Site is unable to provide the dates requested on this form.

- **Please Note:** Only provide interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.

#	Question	Entry Alternatives	Working Instructions
i	Has this TSS received permission from the NCI to provide time intervals as a substitute for requested dates on this form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If the answer to this question is yes, time intervals must be provided instead of dates, as indicated throughout this form. Provided time intervals must begin with the date of initial pathologic diagnosis (i.e. biopsy or resection). Only provide interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.
ii	Number of Days from Date of Initial Pathologic Diagnosis to Date of Birth	_____ days	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the patient's date of birth. 3008233
iii	Age at Initial Diagnosis	_____	Provide the age of the patient in years, at the time the patient was initially pathologically diagnosed. 2006657
iv	Number of Days from Date of Initial Pathologic Diagnosis to Date of Last Contact	_____ days	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date of last contact. 3008273 Do not answer this question if the patient is deceased.
v	Number of Days from Date of Initial Pathologic Diagnosis to Date of Death	_____ days	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date of death. 3165475
vi	Number of Days from Date of Initial Pathologic Diagnosis to Date of New Tumor Event After Initial Treatment	_____ days	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the date of new tumor event after initial treatment. 3392464

Principal Investigator or Designee Signature

Print Name

____/____/____
Date